COMPOUND FRACTURE OF THE NECK OF THE SCAPULA AND SIMPLE FRACTURE OF THE SHAFT OF THE HUMERUS BELOW THE INSERTION OF THE DELTOID.

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ON June 27th, 1895, a trooper was riding on the front of a regimental transport in N'gamiland, and when trying to step off slipped to the ground, falling on his back, the front wheel passing over the shaft of the right humerus and shoulder. I examined him a few minutes after the accident occurred, and found there was marked projection of the acromion, and a considerable interval between it and the head of the humerus. The deltoid was flattened, the limb had sunk into the axilla, and the coracoid process was movable and at a lower level than that of the opposite side. Crepitus could be produced. There was also a wound on the back opposite the shoulder-joint, which was caused by a stone in the sand. When the probe was used the injured part was found to communicate with the fractured neck of the scapula. The humerus was also fractured below the insertion of the deltoid. The following was the treatment adopted. The wound at the back of the shoulder was syringed with an antiseptic and dressed with iodoform. I applied an angular internal splint from the axilla to the wrist, fashioned so as to project a little below the elbow. The axillary end of the splint was shaped and padded so that it would principally support the anterior and posterior axillary borders, thus avoiding pressure on the vessels. Three short splints were placed on the other sides of the limb. The angular splint was now pushed well up into the axilla, and the four splints were bandaged to the limb; and then, after binding the arm to the side with a broad bandage, a sling was applied well supporting the projection of the angular splint at the elbow, as well as the forearm, which was kept midway between supination and pronation. When seen on Sept. 28th the patient had made an excellent recovery without deformity and had returned to duty.

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NOTES ON A CASE OF LYMPHADENOMA; EFFUSION INTO THE RIGHT PLEURA; PRESSURE ON THE RIGHT BRONCHUS.

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THE following case may be read in connexion with a very instructive one reported by Dr. H. Sainsbury in THE LANCET of Nov. 30th, 1895.

Seventeen years ago I was suddenly sent for to see a man who had great difficulty in breathing. On my arrival I found the patient very anæmic and with an anxious expression. The history was, briefly, that he had been in the Australian bush for about four years, and that his health had been failing for two years, during which latter period his glands had gradually become enlarged. He had returned to England to put himself under the care of Sir William Jenner who had, I think, only seen the patient once or twice before I was called in, and in a consultation the same evening Sir William Jenner told me there was no evidence of fluid in the chest when he examined it a few days before. On examination there was general lymphadenoma, with urgent dyspnœa, and the right chest was airless and full of fluid. It was resolved to tap the chest, which I did with a small trocar, but only about two drachms of fluid came away. On a second consultation Sir William Jenner questioned my having entered the pleural cavity, or, even if I had, that the cannula was too small. I accordingly used an abdominal trocar, but with no better result. The patient died the following day. At the post-mortem examination, not only was there pressure on the large veins sufficient to account for the effusion, but the right bronchus was so compressed as to prevent the ingress of air into the lung. Both punctures were seen to be into the pleural cavity, so the dryness of the tapping was owing to the physical conditions within the chest, which, though different from those found in Dr. Sainsbury's case, had a similar effect in not permitting withdrawal of the fluid; there was "no vent" whereby the air could enter.

Weymouth-street, W.

A Mirror OF HOSPITAL PRACTICE, BRITISH AND FOREIGN.

Nulla autem est alia pro certo noscendi via, nisi quamplurimas et morborum et dissectionum historias, tum aliorum tum proprias collectas habere, et inter se comparare.—MORGAGNI *De Sed. et Caus. Morb.*, lib. iv. Procemium.

CHARING-CROSS HOSPITAL.

TWO CASES OF TYPHOID FEVER, BOTH COMPLICATED BY HÆMATEMESIS, AND ONE BY HÆMORRHAGE; ONE RECOVERY; ONE DEATH.

(Under the care of Dr. GREEN and Dr. J. GALLOWAY.)

INTESTINAL hæmorrhage in the course of typhoid fever is not infrequent, but it is rather difficult to estimate the percentage of cases in which it occurs. One way of estimating it is by taking the percentage of those known to have suffered from it in a certain number of fatal cases, as was done by Hölscher, who found a history of intestinal hæmorrhage in 5 per cent. This, of course, gives but an inadequate idea of its prevalence, for many patients subsequently recover. "Hæmorrhage from the bowel in enteric fever occasionally coexists with hæmorrhage elsewhere, such as epistaxis, hæmoptysis, hæmatemesis, hæmaturia, bleeding from the gums, and purpuric spots, and then the disease has been designated 'hæmorrhagic putrid fever.'"[1] In both the present cases there was vomiting of blood, which was probably dependent on a congested condition of the mucous membrane of the stomach. For the notes of these cases we are indebted to Mr. William Escombe, house physician.

CASE 1. (*Under the care of Dr. Green.*) *Typhoid fever; hæmatemesis; hæmorrhage; relapse.*—The patient, a female aged twenty-three years, was admitted to hospital on Sept. 21st, 1895. Her temperature was 101° F. Her illness commenced with headache and pains on Sept. 10th. Her condition on admission was as follows. She was lying on her back; her cheeks were rather flushed, and her expression was somewhat vacant; she was quite conscious, and her memory was good. Her pulse was 104 and dicrotic. The tongue was furred down the centre; the tip and edges were clean. Her abdomen was somewhat distended; there were a few spots typical of typhoid fever. The spleen was easily palpable. The heart and lungs were normal. The urine was highly coloured and clear, and the specific gravity was 1014; there was a large trace of albumin. On Sept. 22nd the patient complained of pain in the left thigh. On examination some œdema of the left leg was found; the upper part of the left thigh was red and tender, and a cord could be felt in the course of the femoral vein. There was slight diarrhœa and the stools were typically "typhoid in character." The fever ran a normal course after this until Sept. 27th, when some blood was passed in the stools. On the following day, at 1 P.M., the patient had an attack of hæmatemesis; the blood was dark-coloured, but was not measured as it was vomited into the bed. This was followed one hour and a half afterwards by a second attack; the blood was of the same character as before and measured two ounces. The patient was treated with a hypodermic injection of morphia; all food was ordered to be fully peptonised, and one drachm of the saccharated solution of lime was added to each five-ounce feed. She was also ordered ice to suck. The pulse was 120, and the temperature remained high. For the next twenty-four hours the motions were black and tarry in character, but there was no more hæmatemesis. Subsultus tendinum was well-marked, and there was distinct tremor in both hands. There were also dulness and numerous râles at the base of both lungs. From now onwards the temperature fell steadily, but the patient was very weak and was kept upon hypodermic injections of liquor strychniæ, two minims every eight hours, and brandy, four ounces. Ten-grain naphthaline pills, three times in the day, were employed as an intestinal antiseptic. There was no more hæmatemesis or hæmorrhage, but for two consecutive days large erythematous patches lasting about twenty-four hours appeared

[1] Murchison: Continued Fevers, p. 527.

over the chest and abdomen. The thrombosed femoral vein cleared up with no further trouble. Unfortunately, the patient had a severe relapse lasting over twenty-four days, but during the whole of this time she had no bad symptoms and has since made an uninterrupted recovery.

CASE 2. *(Under the care of Dr. Galloway.) Typhoid fever; hæmatemesis; death.*—The patient, a man aged twenty-eight years, was admitted to hospital on Aug. 29th, 1895. His temperature was 101° F. His illness commenced with headache and shivering on Aug. 16th. The patient lay on his back; his face was flushed; the skin was hot and moist. The pupils were slightly dilated. The pulse was 104. The tongue was coated with white fur in the centre; the lips were covered with sordes. The abdomen was uniformly distended; there were spots typical of typhoid fever. The spleen could not be felt owing to muscular rigidity of the abdominal wall. There was tenderness over the right iliac fossa. The heart and lungs were normal. The specific gravity of the urine was 1012, acid, with a large trace of albumin. There was slight diarrhœa of a greenish colour, loose, and offensive; no undigested milk appeared in the stools. The illness ran a normal course until Sept. 1st, when the patient had a distinct and well-marked rigor at half-past nine in the evening; the pulse was 120 and the respiration 24. This was followed by another rigor on the following day at 4.30 P.M.; the pulse was 160 and the respiration 32. There were no physical signs of pneumonia. The diarrhœa continued and was checked by enemata of opium. The patient continued to get weaker, but took all his food well, with occasional slight retching, but no vomiting, until the 7th, when a very troublesome hiccough set in and lasted almost continuously until his death. The pulse became more frequent and running in character. On Sept. 10th vomiting commenced, and the patient brought up blood of a dark-red colour; much of the blood could not be measured, as it was in the bed, but three ounces were actually measured. He became unconscious and died on Sept. 11th.

Necropsy.—The deep ulceration was entirely in the lower end of the small intestine, none of the sloughs having separated; the upper part of the small intestine was ulcerated superficially. The mucous membrane of the stomach was much congested, and on the posterior surface at the pyloric end twenty or thirty petechial spots were visible. There was no evidence of old or recent ulceration. The œsophagus was healthy. There was no ulceration of the larynx.

ROYAL SOUTH HANTS INFIRMARY.

HISTORY OF A CASE OF A TAMARIND STONE IN THE RIGHT BRONCHUS; NECROPSY; REMARKS.

(Under the care of Dr. A. B. WADE.)

THE record of the treatment of a case of foreign body when impacted in a bronchus is always worth reading, and when there are also unusual features presented it is additionally interesting. It is unfortunate that the result in the present instance was fatal, but the case is possibly more important to the profession on account of the emphasis which is thus laid on the necessity of keeping open the tracheotomy wound until the body has been expelled. The condition of the lung, as met with at the post-mortem examination, was that usually resulting from the impaction of a foreign body in the bronchus, and it by no means follows that the child would have recovered from this even if the foreign body had been successfully expelled. Although the collection of a large number of cases gives statistics on this subject, still the prognosis must vary so much in individual cases that they can be of little practical utility. All the bodies impacted in this situation are not of the same size or shape; neither are they of the same material, varying as they have done from the steel blade of a tooth forceps to the foreign body in this case, and the size of the bronchus has varied from that of the adult downwards. Some of the substances impacted are early acted on by the secretions of the part, whilst others are affected only after a long time or not at all. For the notes of this case we are indebted to Mr. W. P. Purvis, F.R.C.S., house surgeon.

A little boy aged five, who had always been thoroughly healthy, was admitted to the Royal South Hants Infirmary, under the care of Dr. Wade, on April 23rd, 1895. A quarter of an hour before he was brought to the hospital he had been eating tamarinds, and was seized with an attack of coughing and choking, which his mother supposed to be due to a stone having stuck in his throat. On admission he had constant and spasmodic cough and a little inspiratory stridor. A large quantity of frothy mucus was secreted. Nothing could be seen or felt in the fauces or larynx. On auscultation it was found that no air was entering the right lung. On being laid down upon the bed he breathed quite easily and showed no distress. During the evening he passed a tamarind stone in a stool, but this only pointed to the fact that he had not been careful about the stones. For the benefit of those who may not recall the exact appearance of a tamarind stone, it may be remarked that, though the West Indian are not quite the same, the East Indian are of a stony hardness and a red colour. In size they vary from one-third to one-fourth of an inch in diameter. They are flat and circular, and about three-sixteenths of an inch thick. Each is enclosed in a tough fibrous husk. On April 25th no air entered the patient's right lung, and the heart was drawn over to the right side, its impulse being felt over a somewhat wide area between the sternum and the right nipple. He had very little cough. His temperature, which had been normal, suddenly ran up to 102·6° F. Under chloroform Dr. Wade performed a low tracheotomy and made search for a foreign body which was presumably impacted in the right bronchus. This might have been either the hard stone or its fibrous husk. Nothing could be felt, and the excursions of the trachea and the reflex cough when the mucous membrane was touched by instruments were very embarrassing to the operator. Inversion was also tried, but without result. A Durham's tube was inserted. On the 28th the temperature was still 100° to 102°. The wound was healthy. The heart seemed to be going back to its normal position. On the 29th the temperature was 101°. The apex-beat was in the normal situation. The patient did not seem to be quite so well. The whole of the right side of the chest was dull on percussion, and there was very loud tubular breathing all over it except at the base behind. On the 30th the silver tube was exchanged for a rubber one, and the patient was very comfortable with it. The temperature was 102·6°. On May 6th the temperature was 98° in the morning, having been 102 2° the evening before. The patient's general condition was not so good. The physical signs were unchanged except that from the front a little air seemed to enter the upper lobe of the right lung. Another attempt to remove the stone on this day was as unsuccessful as the last. No foreign body could be felt at all. Liberal brushing of the trachea with a 20 per cent. solution of cocaine failed to stop the cough reflex. On May 25th the patient seemed to be better in himself, and a little air seemed to enter the right lung. It was not quite so dull as formerly. Since the last date his temperature had been normal or subnormal in the morning, running up to 102° or 104° (105° on one occasion) every night. He had emaciated greatly, but was beginning to pick up again. On the 28th the tracheotomy tube was removed (thirty-sixth day). On the 30th the patient's weight was 2 st. 1 lb. He got up for the first time and continued to do so. On June 7th his weight was 2 st. 4½ lb. The tracheal wound was quite healed. He seemed to be much better, and his temperature did not rise so much at night. On the 13th his weight was 2 st. 4½ lb. On the evening of that day his temperature reached 104°, but he seemed to be about as well as usual, and the physical signs were unchanged. On the 14th (fifty-third day), about 2.15 A.M., he suddenly awoke from sleep, coughing and choking. Mr. Purvis was immediately summoned and lost no time in repairing to the ward. He found the patient pale and with staring eyes. The patient gave a few gasps, but no air entered his chest. By the time Mr. Purvis had reopened the old wound the patient had ceased to breathe and his heart could not be heard. Artificial respiration was performed for some little time, but without avail.

At the post-mortem examination on June 14th, at 2.30 P.M., the body was found to be somewhat wasted. The bean lay impacted just below the cricoid cartilage, filling the trachea from there down to the tracheotomy wound. The mucous membrane of the right bronchus was reddened and slightly softened, but there was no ulceration. The diameter of the tube was markedly greater than that of the left, and the stone had evidently been impacted at about the middle of its length. The right pleura was obliterated, with soft, recent adhesions. The lung was large and completely solid. On section several points of pus appeared, which were the cut ends of bronchioles, the latter being